ST MARY'S
COLLEGE of MARYLAND
The National Public Honors College

OFFICE OF ACCESSIBILITY SERVICES
47645 College Drive
St. Mary's City, MD 20686

www.smcm.edu
TEL: 240-895-4388
FAX: 240-895-2234

Documentation Form for Health-Related Disability

This information submitted to Accessibility Services should reflect the most currently available information. **This Health-Related Disability Documentation Form should:**

a) ***Be completed by a qualified professional.***

b) ***Be completed as clearly and thoroughly as possible.*** Incomplete responses and illegible handwriting may require additional follow up.

c) ***Be supplemented with reports or additional testing, if applicable***. Please do not provide case notes or rating scales without a narrative that explains the results.

Submit Information to:

Office of Accessibility Services

Glendening Hall 230
St. Mary's College of Maryland
47645 College Drive
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SMCM Student Name: SMCM Student ID:

Date form is being completed:

1. Clinician's date of first contact with this student:
2. Clinician's date of last contact with this student:
3. List health conditions/disabilities including severity levels (e.g., mild, moderate, severe, profound):
4. Please check all applicable impacts/symptoms of this health-condition:

   Low/High Blood Glucose
   Levels Anaphylaxis
   Hives/Rash
   Headaches
   Light Sensitivity
   Aural/Visual Field Disturbance
   Fainting
   Dizziness
   Brain Fog
   Urgent/Frequent Restroom Use
   Seizures (Type:
   Muscle Weakness
   Nausea
   Vomiting
   Concentration/Attentional Difficulties
   Sleep Disturbance (Type:
   Pain (List Type & Location of Pain:

5. Please list any other impacts or symptoms that are not listed above:
6. What is the expected duration of the condition and its impact on the individual's daily functioning?

   Permanent (more than 5 years) Less than 1 year
   1-5 years Unknown

7. The condition is:

   Stable Improving Worsening Cyclically Variable

   i. Have there been any changes in the condition the last 12 months? YES NO
   ii. Are any changes in the condition anticipated in the next 12 months? YES NO

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8. The prognosis is:

   Poor   Fair   Good   Excellent

9. Treatment for this condition requires clinical follow-up/support:

   Weekly   Monthly   Quarterly   Twice a year   Yearly

10. Discuss any side effects related to treatment or medications that may be relevant to identifying accommodations.

11. Please state any recommended **residential/dining** accommodations with a rationale.

12. Please state any recommended **academic** accommodations with a rationale.

13. Describe the **strategies and supports that have successfully worked** to address any limitations and why.

14. Please provide any additional information you feel is pertinent or may be of use in the accommodation process.

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Provider Information

Provider Name (Print):

Provider Signature:

License or Certification #:

Address:

Phone: FAX: